Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS841S	A. BUILDING _____ B. WING _____	C 03/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF LAS VEGAS	6151 VEGAS DRIVE LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation under State licensure conducted at your facility on March 9, 2009 and finalized on March 10, 2009. The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations, adopted by the Nevada State Board of Health on August 4, 2004. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as the result of a complaint investigation under State licensure conducted at your facility on 3/9/09. The following complaints were investigated: 1. Complaint #NV00020682 was unsubstantiated. An unrelated deficiency was cited. See Tag Z230 2. Complaint #NV00021195 was substantiated. See Tag Z230 and Z113 3. Complaint #NV00020769 was unsubstantiated. 4. Complaint #NV00020765 was unsubstantiated. 5. Complaint #NV00020240 was substantiated. No deficiency was cited based on the facility's actions. 6. Complaint #NV00019904. A resident to resident altercation was substantiated. No deficiency was cited based on the facility's actions. 7. Complaint #NV00019731 was	Z 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z 000	Continued From page 1 unsubstantiated. 8. Complaint #NV00019586 was unsubstantiated. 9. Complaint #NV00020246 was substantiated. No deficiency was cited based on the facility's actions.	Z 000		
Z113 SS=D	NAC 449.74439 Comprehensive Plan of Care 4. Services provided to a patient in a facility for skilled nursing must: a) Comply with the professional standards of quality applicable to those services; and b) Be provided by qualified persons in accordance with the patient's plan of care. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a registered nurse assessed residents for injury following a fall in accordance with Nevada Administrative Code (NAC) 632 of the Nurse Practice Act for 1 of 14 residents. (#8) Findings include: The nursing roles and responsibilities in NAC 632 specify that the registered nurse assesses and evaluates the health status of groups and individuals and the licensed practical nurse contributes to the assessment of health status by collecting reporting and recording objective and subjective data under the direction of the registered nurse. Resident #8 was admitted to the facility on 12/3/07 with the diagnoses that included Alzheimer's disease, peripheral vascular disease, osteoporosis, hypertension, and dysphagia. Review of the record revealed in a nurse's note	Z113		

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Z113	Continued From page 2 that, on 1/5/09, Resident #8 fell to the ground. She landed on the floor in a sitting position with her head against the wall. A certified nursing assistant (CNA) witnessed the fall and called a licensed practical nurse (LPN) for assistance. The LPN helped the resident transfer to a wheelchair using a gait belt. The resident's vital signs, but no other assessment was noted in the record. The resident's physician was notified and the resident was transferred to an acute care facility for an evaluation. The resident's hip was fractured and the resident was admitted to the acute care facility. An interview was conducted with the Director of Nurses on 3/9/09. She stated that she saw Resident #8 after she was back in bed following the fall. She was unable to provide evidence that a registered nurse had assessed the resident before she was moved from the floor. She revealed that it was the facility policy to not move a resident if the resident was having severe pain. On 3/10/09 at 8:50 AM, a telephone interview was conducted with the LPN who was called to assist Resident #8. She stated that she checked the resident from head to toe. The resident did not have a bump on her head and range of motion revealed no injury. She assisted the resident to the wheelchair with the assistance of two CNA's and a gait belt. The resident was not assessed or evaluated by a registered nurse before she was moved to the wheelchair. Severity 2 Scope 1	Z113		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment	Z230		

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Z230	Continued From page 3 that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to obtain laboratory testing as ordered by the physician for 2 of 14 residents. (#5, #6) Findings include: Resident #5 was admitted to the facility on 1/10/09 from an acute care facility. The resident's diagnosis included hypertension, atrial fibrillation, and osteoarthrosis. Review of the record revealed a physician order written on 1/11/09 for lab work: complete blood count, urinalysis, lipid panel, metabolic panel, thyroid stimulating hormone, and iron/ferritin. Review of the record failed to reveal evidence of a report of the results. An interview was conducted with the Director of Nurses on 3/9/09, to obtain the results of the lab work. The DON was unable to find the results or determine if the lab work was done as ordered. Resident #6 was admitted to the facility on 2/5/09 from an acute care facility following a hemicolectomy. The resident's medical history included anemia, hypertension, mild dementia, and diabetes. Review of the record revealed a physician order for a urinalysis with a culture and sensitivity	Z230		

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Z230	Continued From page 4 written on 2/13/09. No evidence was found in the record that the urinalysis was done on 2/13/09 or why it was not done. On 2/18/09, an order was written to obtain a specimen for the urinalysis with culture and sensitivity by straight cath. The record revealed a lab report indicating that the specimen was collected on 2/19/08, and a note on the report dated 2/21/09, that the facility was waiting for the results of the culture. No evidence of results for the culture and sensitivity was found in the record. An interview with the DON on 3/9/09 failed to reveal a reason why the testing was not done on 2/13/09 as ordered. Severity 2 Scope 1	Z230		